DRAFT *

TEMPLATE FOR LOCAL INFECTIOUS DISEASE EMERGENCY PLANNING AND RESPONSE

MATown, Massachusetts

***This document is a work in progress and will be updated as new information becomes available**.

December 24, 2003

P R E F A C E

A public health infectious disease emergency can overwhelm public and private health systems. Infectious disease outbreaks of various sizes occur frequently in Massachusetts and affect people of all ages, race, gender and health status. They can range from a single case of hepatitis A in a food handler or a few cases of meningitis in high school students to thousands of people potentially infected as a result of an influenza pandemic or bioterrorist event. The initial response to the health and social consequences of an infectious disease emergency will be initiated at the local level with assistance from the state. Therefore, state and local agencies must have a practical plan in place to respond. The Infectious Disease Emergency Plan (IDEP) provides a framework for a coordinated response to such events.

This Template for Infectious Disease Emergency Planning and Response (IDEP) was prepared using *Influenza Pandemic: A Planning Guide for State and Local Officials (Draft 2.1),* distributed by the Council of State and Territorial Epidemiologists; and, *Elements of Effective Bioterrorism Preparedness: A Planning Primer for Local Public Health Agents,* distributed by the National Association of County and City Health Officials. Content review and contributions have been made by members of the State/Local Pandemic Planning Committee, members of the Focus Area B Working Group of the Statewide BT Advisory Committee and staff members of the Division of Epidemiology and Immunization, MDPH.

MAYOR, BOARD OF SELECTMEN, ETC **Local Chief Elected Official**	**Name, Chair** **Local Board of Health**
DATED: _____	**DATED: _____**

Note: Add multiple local CEOs if a multi-community plan/BOH

MATown, Massachusetts, will use this plan for response to an infectious disease emergency. The following are the jurisdictions/municipalities to which this plan applies:

Jurisdiction/Municipalities	Contact

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List of Abbreviations

ALS	Advanced Life Support
BOH	Board of Health
BPHC	Boston Public Health Commission
BT	Bioterrorism
CDC	U. S. Centers For Disease Control and Prevention
HAN	Homeland Alert Network (previously named " MA Health Alert Network")
LEPC	Local Emergency Planning Committee
LHD	Local Health Department
MCEMP	Massachusetts Comprehensive Emergency Management Plan
MDPH	Massachusetts Department of Public Health
MEMA	Massachusetts Emergency Management Agency
MIP	Massachusetts Immunization Program
SNS	Strategic National Stockpile
SLI	State Laboratory Institute

I N T R O D U C T I O N

Purpose

The MATown, Massachusetts, Infectious Disease Emergency Plan (IDEP) has been developed to assist cities and towns in their preparedness activities to respond to an infectious disease emergency, such as an influenza pandemic or bioterrorism agent release, in order to minimize morbidity and mortality, and maintain health care and other essential community services during periods of high absenteeism due to illness.

The IDEP has been specifically designed to serve as an Annex to the Comprehensive Emergency Management Plan (CEMP) and supplements that document. Every effort has been made to integrate the IDEP with the CEMP. In that regard, the IDEP is consistent with existing authorities, planning assumptions, systems and procedures.

Objectives

The objectives of the MATown, Massachusetts, Infectious Disease Emergency Plan are to:

1. Describe courses of action that will minimize morbidity and mortality from an outbreak of infectious disease.
2. Establish procedures to provide for a coordinated effort among cities and towns in response to an infectious disease emergency.
3. Identify emergency response organizations, facilities and other resources that can be utilized during an outbreak of infectious disease.
4. Provide a mechanism to integrate community and facility response procedures.

BASIC INFECTIOUS DISEASE EMERGENCY PLAN (IDEP) OVERVIEW

I. Assumptions upon which IDEP is based

Assumptions: Infectious Disease Emergency

1. Infectious disease emergencies are inevitable.
2. In the event of an infectious disease emergency, local officials, the healthcare community and the general public will look to the local health department to coordinate the response.
3. There will be widespread circulation of conflicting information, misinformation and rumors. Communication must be coordinated among all relevant agencies to ensure consistent messages to all entities involved in the response and to the general public.
4. The infectious disease emergency must take priority until the emergency is resolved.
5. Even during a minor event, such as a case of hepatitis A in a food handler or one case of measles on a college campus, local health departments will be responsible for coordinating the distribution and/or administration of vaccine and other relevant pharmaceuticals in their jurisdiction.

Assumptions: Influenza Pandemic

1. An influenza pandemic is inevitable.
2. There may be very little warning. Most experts believe that we will have between one and six months between the time that a novel influenza strain is identified and the time that outbreaks begin to occur in the United States.
3. Outbreaks may occur simultaneously throughout much of the United States, preventing shifts in human and material resources that normally occur with other natural localized or regional disasters.
4. The effect of an influenza pandemic on individual communities will be relatively prolonged -- weeks to months.
5. The impact of the next pandemic could have a devastating effect on the health and well being of the American public. MDPH estimates that in Massachusetts alone, during a 2 – 3 month period -
    - Up to 4 million persons will be infected
    - Up to 2 million persons will become clinically ill
    - Up to 1 million persons will require outpatient care
    - Up to 24,000 persons will be hospitalized
    - Up to 6,000 persons will die
6. Effective preventive and therapeutic measures -- including vaccines and antiviral agents -- will likely be in short supply, as well as antibiotics to treat secondary infections.

7. Health-care workers and other first responders will likely be at even higher risk of exposure and illness than the general population, further impeding the care of victims.
8. Widespread illness in the community will also increase the likelihood of sudden and potentially significant shortages of personnel in other sectors who provide critical community services, including but not limited to, military personnel, police, firefighters, utility workers, and transportation workers.

Assumptions: Bioterrorism

1. Although possible, and likely in a national or global sense, an act of bioterrorism is unlikely in any given location.
2. The release of a biological agent will likely go unnoticed until infected persons present for medical treatment.
3. Most local public health and health care systems will be overwhelmed by community requests for information, prophylaxis and treatment when a bioterrorist threat or event becomes public knowledge.
4. Public health officials will need to work closely with law enforcement and other traditional first responders in a bioterrorism event.
5. Illnesses resulting from a bioterrorist release may be very difficult to differentiate from a naturally occurring outbreak of disease.

II. Local IDEP Leadership

Who is in charge during a local infectious disease emergency?

The protection of the health and welfare of the residents of MATown, Massachusetts, must be managed at the local level. Technical assistance, resources and materiel from the state may be provided when requested or in cases where emergency needs exceed the capability of local response resources. However, in a very large outbreak of disease, many communities will be affected and the state may not be able to meet all requests for assistance.

With assistance from state agencies, **local jurisdictions** will be responsible for:

1. Communication of information regarding prevention and control measures and local effects of disease.
2. Maintenance of public health and essential community functions during periods of high absenteeism.
3. Vaccine/pharmaceutical management and administration/dispensing.

III. Plan Maintenance and Development

What is the role of the local health department in infectious disease emergency planning and response?

1. The local health department will assume a leadership role in local infectious disease emergency planning and response. It will:
    - Establish provisions for public notification, comments, etc. These notification and alerting lists should be reviewed quarterly.
    - Develop and maintain an IDEP in collaboration with other local agencies.
    - Identify resources (personnel, supplies), both available and needed, to carry out an emergency immunization/medication dispensing clinic.
    - Assist other departments and agencies with IDEP plan development.
    - Coordinate IDEP exercises as needed.
    - Conduct IDEP training as needed.
2. Other local departments and agencies with responsibilities under this plan will develop and maintain procedures for implementing an IDEP. These procedures will be reviewed at least annually and revised as needed.
3. The Commonwealth of Massachusetts shall provide assistance to local health departments as provided for in the Commonwealth of Massachusetts Comprehensive Emergency Management Plan.

With whom should the local health department work to develop and maintain the IDEP?

The local health department should work with the local emergency planning committee (LEPC) to develop the IDEP. The Massachusetts Department of Public Health (MDPH) and the Massachusetts Emergency Management Agency (MEMA) will be available to lend technical assistance for plan development. Items that shall be reviewed annually for possible updating include, but are not limited to, the following:

1. Community and facility notification and alerting lists, including identity and phone numbers of appropriate personnel.
2. Lists of priority personnel for receipt of vaccine/pharmaceuticals.
3. Inventories of critical equipment, supplies, and other resources.

In addition, facility and community-specific functions and procedures should be reviewed and revised as appropriate.

What is the policy for updating the IDEP?

The following policies apply to the review and updating of an IDEP.

1. It is the responsibility of the chief local health official to coordinate the review and update of an IDEP. The departments, agencies, communities, facilities, and others who have a role in infectious disease response under the plan will provide support. It is the responsibility of the mayor or the chief executive of each community to delegate responsibility for updating of community information.
2. The plan should be updated as necessary on an annual basis. The plan should have been completed or reviewed within the past year.
3. Departments, agencies and facilities that maintain annexes and/or procedures that are a part of this plan should review that portion of the plan pertaining to their function on an annual basis.

4. The chief local health officer should facilitate and ensure the distribution of the updated plan to appropriate entities.

SECTION A
DIRECTION AND CONTROL

I. Purpose

To provide for effective leadership, coordination and unified response during an infectious disease emergency.

II. Situation

All communities have emergency preparedness plans sometimes known as the Comprehensive Emergency Management Plan (CEMP) -- to cope with major disasters such as hurricanes, plane crashes and hazardous materials events. These plans address many aspects of planning, including command and control functions, descriptions of emergency communication systems, hospital and medical care resources, and other key response elements that are relevant to infectious disease emergencies. However, infectious disease planning will require additional functions that are usually not included in the CEMP, such as delivery of vaccines and pharmaceuticals. One of the main differences between some infectious disease emergencies and other natural disasters is the widespread nature of health effects (along with disruption of critical human infrastructure because of those health effects), which require expansion of the typical disaster management team.

What are the essential functions for which <u>operational</u> <u>procedures</u> should be developed?
The local health department should oversee the development and implementation of operational procedures relevant to infectious diseases for the following essential functions:

- **Communications (Section B)**
- **Emergency Response (Section C)**
- **Emergency Clinic Management and Operations (Section D)**

An infectious disease emergency will require a broad range of planning and response organizations including local government, public health, medical, emergency response, social service, media and law enforcement. Public health and medical response organizations are typically trained to operate within their agency command structure. They are rarely called upon to perform their duties as part of a unified and integrated multi-organizational response, such as that required for an infectious disease emergency. Therefore, this plan calls for implementation of a strong system of direction and control.

What local agencies and staff should participate in infectious disease emergency planning and response? (See Worksheet 1)

- Local hospitals or health centers
- Local public health
- Emergency medical services
- Local health care providers (including nursing organizations)

- Police department

- Fire department
- Animal inspectors
- Animal control officers (ACOs)
- Veterinarians
- Public information officer (or designee)
- School nurse(s)
- School administrator
- Representative(s) from the business community
- Representative(s) from civic and volunteer organizations
- Local media
- Social service organizations

III. Response Procedures

Which state agency is responsible for infectious disease emergency planning and response?

The MDPH is the lead state agency for response to an infectious disease emergency. The MDPH will disseminate information regarding an infectious disease emergency to the local health department, including information on prevention and control. The MDPH also advises the Massachusetts Emergency Management Agency (MEMA) about directing additional resources to local communities to assist in responding to infectious disease emergencies.

What is local unified command?

This plan addresses the need to ensure direction and control for a multi-jurisdiction/multi-agency response to an outbreak of disease. The concept of unified command means that all agencies that have jurisdictional responsibilities and authority at an incident will contribute to -

- Determining overall response objectives
- Selecting response strategies
- Ensuring joint planning and application of tactical activities
- Ensuring integrated planning and application of operational requirements including emergency measures and vaccine management/pharmaceutical distribution
- Maximizing use of available resources
- Ensuring dissemination of accurate and consistent information

What is the role of the mayor or chief elected official in infectious disease emergency planning and response?

The chief elected official of the community is responsible for the health and safety of the citizens of the community.

Prior to an infectious disease emergency, the chief elected official should have appointed a

local infectious disease coordinator *and* ***a public information officer****.*

During an infectious disease emergency, the chief elected official will -

- Decide whether the local infectious disease coordinator or someone else will function as the incident commander during an infectious disease emergency.
- Assess the overall situation including the level of resources needed to deal with the problem.
- Determine who has resources and capacities to share in an infectious disease emergency and how these resources can be obtained.
- Consider the need for a local emergency declaration in consultation with the infectious disease coordinator and emergency manager.
- Be provided with copies of all press releases and summaries of all statements provided to the media in live or taped broadcasts.
- Set up regular situation updates with the infectious disease coordinator.
- Refer specific questions to the public information officer, but be prepared to answer policy related questions in coordination with the incident commander.

Who is responsible for infectious disease emergency planning and response? (See Worksheet 2)

The chief elected official should appoint a *l**ocal infectious disease coordinator***. The local infectious disease coordinator may be the director of health or another person. The local infectious disease coordinator is responsible for planning and managing an infectious disease emergency during the pre-emergency period, during an emerging alert, and during the emergency and post emergency periods.

SECTION B
COMMUNICATIONS

I. Purpose

To ensure an efficient flow of accurate and consistent information during an infectious disease emergency, to facilitate communication among federal, state and local agencies about disease activity and to describe the system for providing information to the general public through the media and other information outlets.

Dissemination and sharing of timely and accurate information among public health officials, government officials, medical care providers, the media and the general public will be one of the most important facets of the response.

For more information please see Model Emergency Response Communications Plan for Infectious Disease Outbreaks and Bioterrorism Events at http://www.astdhpphe.org/bioterr/bioterror.pdf.

II. Assumptions upon which the Communications Section of the IDEP is based

1. Different types of information will have to be communicated, often to different audiences.
2. There will be widespread circulation of conflicting information, misinformation and rumors. Communication must be coordinated among all relevant agencies to ensure consistent messages to the general public.
3. There will be a great demand for accurate and timely information regarding:
    - How many are ill, who is affected and where they are
    - Basic disease information
    - Disease complications and mortality
    - Disease control efforts, including availability and use of vaccines, antivirals and other preventive and treatment measures
    - "Do's and Don'ts" for the general public
    - Availability of essential community services
4. At the state level, it is possible that a priority list for receipt of vaccine/pharmaceuticals will be needed. Depending on existing supplies and supplies available through the Strategic National Stockpile (SNS), there will be a special need for information for the general public about availability of vaccine/pharmaceuticals. In the event of shortages, the targeted group may have to be further prioritized. Information should include the rationale for the list, how decisions were made, and what other control measures people can take until vaccine and or antibiotics are available for everyone.
5. Public education will be an important part of the immunization/pharmaceutical campaign because it is likely that the following problems will be encountered:

- Any symptom or illness that closely follows vaccination may be attributed to the vaccine and any febrile respiratory illness that occurs post-vaccination will be viewed as vaccine failure. (ED Kilbourne. National Immunization for Pandemic Influenza. Hospital Practice 1976:15-21)
- Prophylactic antibiotics/antivirals may need to be taken for a period of up to 60 days, or longer, and the recipient will need clear instructions on how to complete the course of treatment and where to get additional doses of antibiotics/antivirals.

6. Certain groups will be hard to reach, including people whose primary language is not English, people who are homeless, people who are hearing and visually impaired, etc. Local resources, such as community-based organizations, mutual assistance or associations, and linguistically and culturally relevant media outlets should be identified prospectively.
7. During a prolonged infectious disease emergency such as an influenza pandemic or a person to person transmitted BT event, demand for information by health care providers will be so great that traditional methods for educating health care providers will have to be expanded.

III. Risk Communication

Risk communication is a shared responsibility between the MDPH and local health departments. Communicating the threat of disease to the public in a manner that provides meaningful information to help the public respond to that threat is an important aspect of communication protocols. An effective risk communication program should identify and prioritize the audience; deliver a message that is understandable and based on science; and should be delivered through usual or familiar channels.

Note: A risk communication plan is currently under development and will be added to this template as Annex 2 as soon as it is available.

IV. State Communication Response Procedure

What is the Massachusetts Homeland Alert Network (HAN)?

The Massachusetts Homeland Alert Network will provide state and local public health agencies with an enhanced communication system designed to support bioterrorism preparedness including response planning, educational services, disease surveillance, laboratory reporting and epidemiologic investigation. All relevant agencies will have the ability via a web-based system to disseminate information immediately through e-mail, alpha-numeric pagers, fax and voice communications. MDPH is coordinating the implementation and training of local users to ensure a comprehensive understanding of the network. As of November 2003, the HAN is in pilot phase to ensure acceptance from end users and test new state of the art technologies including remote wireless access. Until the HAN is fully implemented statewide, information, recommendations and guidelines will be available to LHDs, health care providers and other public health agencies through:

- MDPH web site: fact sheets and guidelines on control measures, epidemiologic information appropriate for the public and links to other CDC and informational sites. The MDPH website URL is www.state.ma.us/dph.
- MDPH Information Telephone Line: 866-627-7968
- MDPH Division of Epidemiology and Immunization on-call staff: epidemiologists are available 24/7 to respond to telephone calls from providers. The on-call epidemiologists can be reached by calling 617-983-6800.
- Division of Epidemiology and Immunization Surveillance Unit broadcast faxing and fax on-demand to LHDs.
- Mass mailings: MDPH maintains databases of LHDs, health care providers, hospitals and other health care agencies/facilities.
- Newsletter articles.
- Conference calls and satellite programming for education and training.

What are the communication responsibilities of the Massachusetts Department of Public Health (MDPH), Bureau of Communicable Disease Control?

During an infectious disease emergency, the MDPH, Bureau of Communicable Disease Control, will have primary responsibility for:

- Collecting and interpreting surveillance data (as reported from LHDs, laboratories and medical providers), and for disseminating this information to federal, local and other state agencies, health care providers and hospitals.
- Providing up-to-date information on the infectious disease emergency to other bureaus/programs within MDPH.
- Developing and disseminating prevention, diagnosis and treatment of communicable diseases guidelines to local health departments, health care providers and hospitals (specifically hospital administrators, hospital disaster coordinators, emergency department directors, infection control nurses, hospital epidemiologists, and infectious disease directors).
- Communicating with special groups (shared responsibility with LHDs). In order to ensure that all residents of the community have access to information about disease control measures and available services, the MDPH will conduct the following activities-
    - Develop informational materials in appropriate languages.
    - Identify and work with non-English media. Communities with non-English speaking populations should consider having pre-scripted information in their languages as part of this annex.
    - Utilize all programs within MDPH with constituents in communities where the primary language is not English, and in other special groups, e.g., people who are homeless, people who are homebound, etc. These programs include, but are not limited to, Primary Care, WIC, Refugee and Immigrant Health, Community Planning, Bureau of Substance Abuse, Elder Health, etc.
    - Identify groups who can ensure that information is accessible to people who are visually or hearing impaired.

V. Local Communication Response Procedures

What are the communication responsibilities of the local health department?

- During an infectious disease emergency, the local health department will have primary responsibility for:
- Meeting with the local infectious disease planning coordinator and public information officer to review the communication plan. The public information officer should monitor the situation and be prepared to respond to public and media requests for information.
- Setting up a **Local Joint Information Center** with the public information officer to provide and disseminate accurate information to the general public.
- Releasing information through the Local Joint Information Center concerning what volunteer goods and services are needed, and where volunteers and donors may go to deliver such goods or potential services.
- Gathering all records kept during all phases of the incident and preparing a chronological summary of events, actions taken, inquiries made, and response given.
- Collecting newspaper clippings and TV videotapes, if available.
- Surveying the local emergency planning committee and the local media for suggestions to improve emergency response procedures for future emergencies.

What is the role of the local public information officer?

All news releases should be handled by the authorized public information officer. **(See Worksheet 4)**

What are the responsibilities of the public information officer during an emergency?

During an infectious disease emergency, the public information officer will have primary responsibility for:

- Ensuring that all information is clear, confirmed and approved by appropriate authority before release to the media or public.
- Not releasing unconfirmed information or speculating on the extent of the emergency, despite repeated urging by reporters to do so.
- Monitoring news programs and reviewing news articles for accuracy and correcting serious misinformation whenever possible.
- Establishing a Joint Information Center/Media Center and providing sufficient staffing and telephones to handle incoming media and public inquiries and gathering information.
- Providing public information according to priorities.
- Ensuring that official spokespersons are thoroughly briefed about all aspects of the emergency.
- Keeping the infectious disease planning coordinator informed of all media actions taken or planned.
- Keeping public information officers in other jurisdictions and at other government levels informed of information released.
- Maintaining a log and file of all information.
- Releasing emergency instructions/information to the public as necessary. (Closing of public facilities, where to get vaccine, etc.).

- Releasing prevention, control and treatment information, as appropriate.
- Responding promptly to media and public calls.
- Releasing public inquiry ("rumor control") telephone line number when it is staffed.
- Attending periodic briefings and planning sessions.
- Considering additional methods of distributing emergency instructions.
- Arranging media briefings/press conferences on a regular or "as needed" basis.
- Preparing news releases, as required.
- Providing emergency information in foreign languages, as required.
- Releasing morbidity and mortality figures when obtained.

What about communicating with special needs populations/groups? (See Worksheet 5)

As part of infectious disease planning, local health departments should identify groups in their communities that will require special efforts to ensure that they receive all the information necessary to protect them during an infectious disease emergency. Outreach conducted during the pre-emergency period will ensure that channels are in place to facilitate communication during a real emergency. Special needs populations include but are not limited to: native people (Native Americans, Hawaiians and Pacific Islanders), elderly, children, culturally and/or linguistically distinct communities, deaf and hard of hearing, blind and visually impaired, people with disabilities, people that are homebound, people that are institutionalized, recent immigrants, migrant/seasonal farmworkers, people living with HIV/AIDS (or other immuno-deficient disease), people living with mental illnesses, the homeless and others.

SECTION C

EMERGENCY RESPONSE

I. Purpose

To ensure maintenance of essential medical and other community services during an infectious disease emergency.

II. Assumptions upon which the Emergency Response Section of the IDEP is based

1. Infectious disease emergencies can be broadly grouped into two categories:

   NON-COMMUNICABLE INFECTIOUS DISEASE EMERGENCIES

   The response to non-communicable infectious disease and other biologic emergencies is similar to typical local disasters with little or no advance notice. Examples of non-communicable events include BT attacks with anthrax or widespread foodborne toxicities like paralytic shellfish poisoning mediated through a seafood processing plant. Individuals exposed in a non-communicable event will require medical triage and evaluation. However, the spread of the event will be limited because of the lack of person to person transmission. Chaos and misinformation will be significant problems to contend with. There may be a need for widespread vaccination/medication dispensing clinics.

   COMMUNICABLE INFECTIOUS DISEASE EMERGENCIES

   Communicable infectious disease emergencies, such as an influenza pandemic or a smallpox outbreak, will be widespread, with many geographic areas possibly affected simultaneously. Thus, each community will have to be prepared to act on its own, rather than pooling resources from several contiguous jurisdictions, or relying on state personnel for help. Chaos and misinformation will be significant problems to contend with. There may be a need for widespread vaccination/medication dispensing clinics.

2. If illness associated with an infectious disease emergency is especially severe, health services could easily become overwhelmed very quickly with the following:
   - Shortfalls of ICU beds, ventilators and other critical-care needs
   - Shortages of antibiotics and/or antiviral agents
   - Needs for ancillary or "non-traditional" treatment centers
   - High demand for mortuary/funeral services
   - High demand for social and counseling services

3. Unlike natural disasters, demands on medical care in each community might be prolonged if the illness spreads from person to person.

4. Unlike the typical disaster, essential community service personnel themselves (e.g., medical-care personnel, police, firefighters, ambulance drivers and other first responders) will be just as likely -- or even more likely (because of increased exposure) -- to be affected by a communicable infectious disease emergency than the general public.
5. Because of the threat of exposure to influenza or other infectious diseases, the elderly and other high-risk and special-needs populations may be fearful of leaving their homes to seek medical attention for chronic medical conditions, and may require home visits for basic needs and health care.
6. In summary, high attack rates of a communicable disease or the perception of personal danger will place overwhelming demands on the health care system. Health care providers, emergency response and public safety personnel will be equally or more likely to become infected than the general public. Certain high-risk groups will be less likely to have access to information and services (e.g., people who are homeless, homebound, poor, undocumented or who do not speak English). Because the epidemic can be widespread, it is unlikely that resources could be diverted from other geographic areas. Every community will have to be prepared to be self-sufficient, while at the same time sharing resources such as hospitals, mortuary services, etc.

III. Response Procedures (See Worksheets 7-17)

Is there particular information pertaining to Isolation and Quarantine that local health departments should be aware of?

In order to contain the spread of a contagious illness, public health authorities rely on many strategies. Two of these strategies are isolation and quarantine. Both are common practices in public health and both aim to control exposure to infected or potentially infected individuals. Both may be undertaken voluntarily or compelled by public health authorities. The two strategies differ in that isolation applies to people who are known to have an illness and quarantine applies to those who have been exposed to an illness but who may or may not become infected.

ISOLATION: For people who are ill

Isolation of people who have a specific illness separates them from healthy people and restricts their movement to stop the spread of that illness. Isolation allows for the focused delivery of specialized health care to people who are ill, and it protects healthy people from getting sick. People in isolation may be cared for in their homes, in hospitals, or at designated health care facilities. Isolation is a standard procedure used in hospitals today for patients with tuberculosis (TB) and certain other infectious diseases. In most cases, isolation is voluntary; however, many levels of government (federal, state, and local) have basic authority to compel isolation of sick people to protect the public.

QUARANTINE: For people who have been exposed but are not ill

Quarantine, in contrast, applies to people who have been exposed and may be infected but are not yet ill. Separating exposed people and restricting their movements is intended to stop the spread of that illness.

Do state and/or local health departments have statutory authority to isolate or quarantine individuals?

M.G.L c.111s.6 provides that "the Department shall have the power to define, and shall from time to time define, what diseases shall be deemed to be dangerous to the public health, and shall make such rules and regulations consistent with law for the control and prevention of such diseases as it deems advisable for the protection of the public health." Further regulations found in 105 CMR 300.200 define diseases and establishes minimum isolation and quarantine requirements.

Note: a comprehensive listing of Massachusetts's laws and regulations pertaining to isolation and quarantine will be developed and added to this document as an appendix.

Note: The Boston Public Health Commission (BPHC) has adopted the "Regulation for the Isolation and Quarantine of Individuals with Infectious Disease Dangerous to the Public Health." A copy of this act may be found at the web address: http://www.bphc.org/bphc/pdfs/regs_quarantine.pdf

What about contingency plans to meet the needs of persons confined to their homes?

During an extended or widespread emergency, persons may be confined to their homes by choice, out of fear of being exposed and becoming ill, or by direction from state or local health officials in order to reduce transmission in the community.

The provision of food, medical and other essential support for persons confined to their homes will be the responsibility of local communities. Local communities are encouraged to make use of civic organizations and other volunteers to meet these needs. For instance, local agencies already engaged in providing services to the homebound (Meals-on-Wheels, etc.) may become the nucleus for voluntary efforts to provide services to people confined to their homes.

In addition, there will likely be situations in which care providers of children, people with special needs or the elderly will become ill and unable to care for their dependents.

Communities will need to have plans in place to identify these situations (e.g., hotlines and or home visiting programs) and contingency plans to care for these individuals. Resources to staff hotlines or home visiting programs include civic/volunteer organizations, local colleges and senior citizens. Using these resources on a regular basis to staff flu clinics, health fairs, etc. will ensure a ready group of volunteers in an infectious disease emergency.

What about medical care for people sick at home?

Families will need information about how to take care of sick family members at home, and guidelines regarding when to seek professional medical care. This first-line triage will be essential to eliminating unnecessary calls and decreasing the burden on health care providers, freeing them to care for the seriously ill.

What about maintenance of other essential community services?

Personnel who provide essential community services, including public safety and emergency

response, will be as likely to become ill during an infectious disease emergency as the general public. Contingency plans for back up for essential personnel during periods of high absenteeism need to be in place to ensure continuation of essential community services during the pandemic.

Each local agency should develop (or review and update existing lists) of essential services and personnel. Contingency plans should be developed to provide backup for any personnel whose absence would pose a threat to public safety or would significantly interfere with the on-going response to the pandemic. Backup personnel could come from reassignment of personnel from non-essential programs within local agencies, retired personnel and/or private-sector personnel with relevant expertise.

Note: In order to insure that essential service staff will be able to report for duty during an emergency, it is essential that personal or family contingency planning is in place. Draft examples of this type of planning will be included in future versions of this template.

SECTION D

EMERGENCY CLINIC MANAGEMENT AND OPERATIONS

(This section is in development)

A. Siting Guidance

B. Standing Orders (models from the MIP)

C. Personnel Needs: clinical and non-clinical

D. Communication Needs

E. Equipment Needs

F. Strategic National Stockpile (SNS)

The mission of CDC's Strategic National Stockpile (SNS) Program is to ensure the availability and rapid deployment of life-saving pharmaceuticals, antidotes, other medical supplies and equipment necessary to counter the effects of nerve agents, biological pathogens, and chemical agents. The SNS Program stands ready for immediate deployment of assets to any U.S. location in the event of a terrorist attack or other emergency involving a biological toxin or chemical agent that affects a civilian population.

A plan for the emergency distribution of SNS assets throughout Massachusetts is currently under development. MDPH, working with MEMA, would oversee such distribution to communities in the event of an emergency. Local health departments and local emergency planning officials, in coordination with regional BT staff, will have the opportunity to work with the MDPH SNS staff to strategize how SNS assets would be utilized at the local level. Guidelines for LHD use of SNS assets, including the management of emergency medication dispensing clinics, will be added to this plan as soon as they are available.

INFECTIOUS DISEASE EMERGENCY PLAN TEMPLATE

WORKSHEETS

SECTION A – DIRECTION AND CONTROL

Worksheet 1: Leadership Roles

POSITION	NAME / DEPARTMENT / AGENCY	TELEPHONE Work/home
Chief Executive		
Health Director		
Local Infectious Disease Coordinator		
Public Health Nurse(s)		
Emergency Management Coordinators		
Hospital/ Health Center Disaster Coordinators		
Emergency Medical Services		
PIO (Public Information Officer (Designee)		
Animal Control Officer		
Animal Inspector		
Volunteer Resources		
Police Department		
Fire Department		
Public Utilities		

Public Works Dept.		
Schools		
Council on Aging		
(Other)		

SECTION A – DIRECTION AND CONTROL

Worksheet 2: Responsibilities of Local Infectious Disease Coordinator

COMPLETION DATE	PRE-EMERGENCY ACTIVITIES
	Provide training in emergency response for all personnel who would be involved in responding to an infectious disease emergency. Training opportunities are available from MEMA at www.state.ma.us/mema/training/train.htm.
	Ensure that a local infectious disease plan is developed either as an annex or supplement to the community's existing All Hazards Emergency Operations Plan or as a stand-alone plan.
	Identify gaps in the local infrastructure and resources that, if not corrected in advance, may interfere with an effective response.
	Identify the number and location(s) of emergency medication dispensing/administration clinics necessary to meet treatment needs of entire population of the community.
	Develop a "marketing strategy" to inform key government officials, legislators, and various stakeholders of the need to address and resolve these gaps in advance of an infectious disease emergency.
	Coordinate planning activities with bordering jurisdictions and unique populations.
	Review and modify the plan as needed on a periodic basis, at least annually.
COMPLETION DATE	**NOVEL VIRUS OR EMERGING INFECTION ALERT ACTIVITIES**
	Meet with appropriate partners and stakeholders to review major elements of the plan.
	Modify the plan as needed on an urgent basis to address potential risk

COMPLETION DATE	DURING AN EMERGENCY ACTIVITIES
	Activate communications plan.
	Begin vaccine/pharmaceutical distribution if appropriate.
	Notify key government officials and legislators of the need for additional monetary resources (if not already available).
	Begin heightened surveillance at area hospitals and clinics.
	Coordinate activities with neighboring jurisdictions.
	Interface with appropriate counterparts at the State level.
COMPLETION DATE	**POST EMERGENCY ACTIVITIES**
	Review the response to the emergency.
	Identify what aspects the IDEP was inadequate in responding to the emergency.
	Amend the IDEP to reflect response lessons.

Section B COMMUNICATIONS

Worksheet 3: Communications Flow Chart for Infectious Disease Emergencies

(This section is in development)

Worksheet 4: Media Listings

MEDIA ORGANIZATIONS	CONTACT	TELEPHONE	LOCATION
Newspaper			
Newspaper			
Newspaper			
TV Station			
TV Station			
TV Station			
Radio Station			
Radio Station			
Radio Station			

Worksheet 5: Communication with Special Populations

As part of its infectious disease planning, local health departments should identify groups in their communities that will require special efforts to ensure that they receive all the information necessary to protect them during an infectious disease emergency. Outreach conducted during the pre-emergency period will ensure that channels are in place to facilitate communication with special groups during a real emergency. Special groups include non-English speaking populations, hearing or sight impaired, homeless, homebound, etc.

POPULATIONS	AGENCY	CONTACT	TELEPHONE
Example: Elderly **Example: Homeless** **Example: Non-English Speaking**	**Ethos** **People in Peril** **Cambodian American League**		

SECTION C – EMERGENCY RESPONSE

Worksheet 6: Estimating Potential Impact of Pandemic in Community

CDC has developed software to assist local pandemic planners in establishing estimates of the potential impact of the next pandemic in their community. This software can be downloaded from www2.cdc.gov/od/fluaid/default.htm.

CDC Estimates of Percent of Population Affected by the Next Pandemic	Number Affected in Massachusetts (Pop. 6,000,000)	Number Affected in Your Community (Pop.)
Up to 37% of pop. will become ill with flu	2,220,000	
Up to 17% of pop. will require out-patient visits	1,020,000	
Up to 0.4% of pop. will require hospitalization	26,000	
Up to 0.1% of pop. will die of flu-related causes	6,000	

SECTION C – EMERGENCY RESPONSE

Worksheet 7: Response Procedures

COMPLETION DATE	PRE-EMERGENCY ACTIVITIES
	Use Worksheet 6 to establish estimates of the potential impact of the next pandemic in their community. The morbidity and mortality resulting from a bioterrorist release of smallpox or pneumonic plague should be considered even greater.
	Conduct appropriate trainings such as table top exercises for community personnel.
	Develop contingency plans to provide food, medical and other essential needs for persons confined to their homes by choice or by direction from State and local health officials. Enlist appropriate voluntary and/or civic organizations as needed.
	Develop list of essential community services (and corresponding personnel) whose absence would pose a serious threat to public safety or would significantly interfere with the ongoing response to the emergency.
	Develop contingency plans for emergency back up of such services and/or provision of replacement personnel. Replacement personnel could come from lists of retired personnel and/or government or private sector employees with relevant expertise. (Note: critical personnel in the non-health sector should also be considered as high-priority candidates for vaccination and/or chemoprophylaxis.)
	Develop contingency plans.
COMPLETION DATE	**DURING THE EMERGING INFECTION ALERT ACTIVITIES**
	Meet with appropriate partners and stakeholders to review major elements of the health sector and essential non-health sector response plans.
	Modify plan as needed to account for updates, if any, on projected impact of the emergency.
	Implement contingency plans, for obtaining critical equipment (e.g., ventilators) and drugs (e.g., antibiotics for treatment of secondary pneumonia).
	Meet with appropriate partners and stakeholders and review major elements of the plan.
	Modify the plan as needed on an urgent basis.
	Ensure that human resources and logistics are in place to provide medical care and to maintain essential community services.

	Coordinate activities with bordering jurisdictions.
COMPLETION DATE	**DURING AN EMERGENCY ACTIVITIES**
	Fully activate the plan.
	Coordinate activities with neighboring jurisdictions.
	Interface with appropriate counterparts at the State level.

SECTION C – EMERGENCY RESPONSE

Worksheet 8: Hospital/Health Center Infrastructure

HOSPITAL/HEALTH CENTER	MUNICIPALITY	CONTACT PERSON	TELEPHONE

Worksheet 9: Ambulance Services

MUNICIPALITY COVERED	AMBULANCE SERVICE	ALS CAPABILITY?	TELEPHONE
MATown	ACME Ambulance	Yes	911

Worksheet 10: Back-Up Nursing Staff (VNA's, School nurses, Clinical Temp. Agencies, Corporate nurses, volunteers)

NAME	AGENCY/ ORGANIZATION	TELEPHONE

Worksheet 11: Funeral Homes

FACILITY	CONTACT	TELEPHONE	# BODIES ABLE TO HOLD

Worksheet 12: Backup Emergency Facilities (hotels, college dormitories, municipal buildings, churches, sports facilities, etc)

FACILITY	FACILITY DIRECTOR	TELEPHONE

Worksheet 13: Pharmacies

PHARMACY	ADDRESS	TELEPHONE	PHARMACY MANAGER

Worksheet 14: Schools

SCHOOL	ADDRESS	TELEPHONE	PRINCIPAL	# STUDENTS ENROLLED

Worksheet 15: Child Care Centers

CHILD CARE CENTER	ADDRESS	TELEPHONE	DIRECTOR	# CHILDREN ENROLLED

Worksheet 16: Special Needs Facilities (long term care facilities, group homes, jails and prisons, etc)

During a communicable infectious disease emergency, facilities that house populations with special needs may experience severe staffing shortages due to illness among employees. Contingency plans should be established to meet the needs of special populations during periods of high absenteeism on the part of their caregivers.

FACILITY	POPULATION	CONTACT	TELEPHONE

Worksheet 17: Veterinarians/Veterinary Laboratories

VETERINARY PRACTICE/LAB	CONTACT	TELEPHONE

Worksheet 18: Social Service Organizations (Big Brother/Big Sister, Any Baby Can, ABCD, Parenting Coalition, etc.)

NAME	ORGANIZATION	TELEPHONE

INFECTIOUS DISEASE EMERGENCY PLAN TEMPLATE

ANNEXES

Annex 1
INFLUENZA VACCINE MANAGEMENT

I. PURPOSE

To provide an efficient system for ordering, storing, distributing and tracking influenza vaccine during a pandemic. Many aspects of this section are applicable to the management of other vaccines and/or pharmaceuticals during an infectious disease emergency.

II. SITUATION

Vaccination will serve as the central preventive strategy during the next pandemic. The amount of vaccine that will have to be managed (ordered, stored, distributed and accounted for) by the local health departments will be affected by the following factors:

- Vaccine availability – manufacturers' ability to produce and distribute vaccine.
- The proportion of available vaccine that will be purchased and distributed by the public versus the private sector.
- Federal, state and local funds available for the public purchase of vaccine.
- Amount of vaccine available for public purchase through federal contract(s).
- Amount of vaccine available for public purchase through contracts negotiated between the state and manufacturers.

III. ASSUMPTIONS UPON WHICH THE INFLUENZA VACCINE MANAGEMENT SECTION OF THE IDEP ARE BASED

1. There will be a minimum of 6 – 8 months between a novel virus alert and the availability of vaccine.
2. The entire population will be susceptible and may require two doses of vaccine, one month apart, for adequate protection.
3. The proportion of influenza vaccine to be distributed and administered through the public versus the private sector is unknown. Even so, the amount, if not the proportion, of vaccine that will be distributed through the public sector during a pandemic will be greater than the amount distributed by the public sector in non-pandemic years.
4. There will be a federal contract for purchase of vaccine.
5. In addition to distributing vaccine, MDPH and local health departments will have plans in place to administer vaccine to residents based on the Priority Groups List established nationally.
6. Administration of vaccine to the general public will occur at the local level. The responsibility of the Massachusetts Immunization Program (MIP) vaccine unit is to ensure the efficient distribution of viable vaccine to 160 local vaccine distributors.
7. Influenza vaccine will be distributed in 10-dose vials.
8. Even if the maximum amount of 12 million doses becomes available for Massachusetts (2 doses for everyone 6 months of age and older), it will arrive over a period of time.

Management of influenza vaccine during the pandemic will most likely occur over a number of months.

9. Because there is likely to be a moderate to severe shortage of vaccine, at least in the early phases of the epidemic, security for the vaccine must be addressed.
10. While distribution of all other vaccines will be maintained during the pandemic, inventories of non-influenza vaccine will be reduced at the regional and local distributor sites.
11. The impending licensure of an over-the-counter, self-administered live, attenuated influenza vaccine may greatly alter the Vaccine Management Plan as it now stands.
12. Although the proportion of influenza vaccine to be purchased in the public versus private sector is not known, it is likely that the public sector will take responsibility, at a minimum, for vaccinating the following groups, based on a pre-determined Priority Groups List:
    - Health care workers
    - First responders
    - Personnel need to maintain essential community services
    - Uninsured residents of the Commonwealth

Special attention must be paid to educating the general public about the Priority Groups List for receipt of vaccine, including the rationale for the list, the process by which the decisions were made, and what other control measures people can take until influenza vaccine is available for everyone. Please see the Communications section of this template for a full description of how information will be disseminated during an infectious disease emergency.

IV. Influenza Vaccine Management

Who is responsible for vaccination of essential local personnel?

Every city and town will use the Priority Groups List to develop its own list of essential community personnel. Each local health department will submit orders for vaccine to the MIP vaccine unit based on this list. Each local community will be responsible for administering vaccine to essential personnel in their community.

How can vaccine be ordered?

CDC will notify the MIP how much vaccine will be available for Massachusetts through a federal contract. Vaccine may also be available through contracts negotiated directly between the MIP and vaccine manufacturers. Once the total amount of available vaccine is known, the MIP will determine the proportion of vaccine that will be held at the State Laboratory Institute (SLI) for administration to essential state personnel (based on the Priority Group List), and how much vaccine will be available to the cities and towns. The MIP will then notify each city and town accordingly.

Because some of the MIP regional offices may not have the capacity to store all the vaccine they will need, a system will be set up by which the regional offices phone into the MDPH vaccine unit the number of doses they distributed that day. The vaccine unit will arrange for that many doses to be delivered the next day to the regional offices where local health departments will pick it up as needed.

What precautions should be taken to ensure the security of the vaccine?

It is important that security during vaccine storage, transport and distribution must be ensured. Central storage of vaccine will remain at the SLI. If additional storage space were needed, one refrigerated tractor-trailer would be adequate to handle storage of 12 million doses of vaccine. Security for vaccine at the SLI and the regional offices, and during transport between those sites will be the responsibility of the MDPH. Security for vaccine during transport between the regional offices and the local distribution sites and during vaccine storage and distribution at the local distribution sites will be the responsibility of the local authorities.

How will vaccine be distributed?

Once it has been received at the central distribution site, vaccine will be moved very quickly through the system to the local health departments. Vaccine will not be stored in any one place for any length of time. As soon as the MIP is notified that vaccine is arriving, the MIP will alert the regional offices, which, in turn, will notify the local distributors. Local health departments will pick up vaccine on an as needed basis so they will not be responsible for storing large amounts of vaccine at any one time.

How will vaccine be accounted for/tracked?

During a pandemic it will be particularly important to maintain strict accountability for vaccine. At the regional offices and local distributor sites, a special log for influenza vaccine will be maintained to record the manufacturer, lot number, expiration date and quantity of vaccine received and distributed.

Local health departments will use the *Vaccine Administration Record*, which is currently used for public immunization clinics. The information recorded on the *Vaccine Administration Record* satisfies the requirements for compliance with federal vaccine administration guidelines.

Education regarding an immunization campaign

Education of the general public will be an important part of the vaccination campaign because as in mass immunization with any vaccine, two problems may occur:

- Any symptom or illness that closely follows immunization will be attributed to the vaccine
- Any febrile respiratory illness following immunization will be viewed as a vaccine failure.

INFLUENZA VACCINE MANAGEMENT WORKSHEET

Worksheet A-1: Response Level Criteria

COMPLETION DATE	PRE-PANDEMIC ACTIVITIES
	Enhance influenza vaccination coverage levels in traditional "high-risk" groups, particularly subgroups in which coverage levels are low - minorities and persons <65 years of age with chronic underlying medical conditions. **Rationale**: Although vaccinating people now will not protect them against influenza during the next pandemic, increasing routine (annual) vaccination coverage levels in these groups now will further reduce the annual toll of influenza and will facilitate access to these populations when the pandemic occurs.
	Enhance pneumococcal vaccination coverage levels in traditional "high-risk" groups (to reduce the incidence and severity of secondary bacterial pneumonia). **Rationale:** Pneumococcal pneumonia is the most common complication of influenza. **Vaccinating people now** who are at risk for pneumococcal disease will protect them now AND during the next pandemic.
	Develop a programmatic scheme for providing influenza vaccine to high-priority target groups and the general population if there is - • Severe vaccine shortages • Moderate vaccine shortages • Adequate vaccine supply
	Consider community-specific modifications or refinements in priority groups, depending on local circumstances. **Rationale:** There may be specific groups of persons in some communities whose absence (due to influenza illness) could pose disastrous consequences in terms of public safety or disruption of essential community services. Examples of such unique, special-skill groups might include nuclear power plant operators, air traffic controllers at major airports, and workers who operate major telecommunications or electrical grids.
	Coordinate proposed vaccine distribution plan with bordering communities.
COMPLETION DATE	**NOVEL VIRUS ALERT ACTIVITIES**

	Modify plan as needed to account for updates, if any, on recommended target groups and projected vaccine supply.
COMPLETION DATE	**PANDEMIC ALERT ACTIVITIES**
	Ensure that human resources and logistics are in place to begin vaccination.
	Coordinate activities with bordering jurisdictions.
COMPLETION DATE	**PANDEMIC IMMINENT STAGE ACTIVITIES**
	When vaccine becomes available, fully activate the vaccination program.
	Coordinate activities with bordering jurisdictions.

Annex 2

RISK COMMUNICATION PLAN

(This section is in development)